NORTHEAST MEDICAL PRODUCTS, INC
520 Boston Post Rd, Old Saybrook, CT 06475
860-388-1437 F: 860-388-0368
www.northeastmedicalproducts.com

GROUP I SUPPORT SURFACE ORDER FORM

Patient Name _____ DOB _____

Address _____ TEL: _____

Diagnosis codes: _____ Length of Need: _____

Equipment ordered:

_____ E0181 Alternating Pressure Pad and Pump
_____ E0185 Gel or Gel Like Pressure Pad for Standard Mattress
(Requires Face-To-Face documentation)

Coverage Questions:

Y N The patient is completely immobile – i.e., patient cannot make changes in body position without assistance.

Y N The patient has limited mobility – i.e., patient cannot independently make changes in body position significant enough to alleviate pressure and at least one of conditions A-D below **(Please select condition(s) below)**

Y N The patient has any stage pressure ulcer on the trunk or pelvis and at least one of conditions A-D below **(Please select condition(s) below)**

A. Impaired nutritional status
B. Fecal or urinary incontinence
C. Altered sensory perception
D. Compromised circulatory status

RELATED CLINICAL INFORMATION
A beneficiary needing a pressure reducing support surface should have a care plan which has been established by the beneficiary's treating practitioner or home care nurse, which is documented in the beneficiary's medical records, and which generally should include the following:

1. Education of the beneficiary and caregiver on the prevention and/or management of pressure ulcers
2. Regular assessment by a nurse, treating practitioner, or other licensed healthcare practitioner
3. Appropriate turning and positioning
4. Appropriate wound care (for a stage 2, 3 or 4 ulcer)
5. Appropriate management of moisture/incontinence
6. Nutritional assessment and intervention consistent with the overall plan of care

Physician Name:	
Address:	
Phone:	FAX:
NPI #:	
Physician Signature:	Date: